Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

KINGWOOD PHYSICAL THERAPY
6318 FM 1488 SUITE 150
MAGNOLIA TEXAS 77354

Respondent Name
INDEMNITY INSURANCE CO

Carrier's Austin Representative
Box Number 15

MFDR Tracking Number
M4-13-2354-01

MFDR Date Received
May 14, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please note that initially claims were being denied due to the documentation did not support codes that were billed, therefore at that time we submitted all detailed documentation and requested a reconsideration for the claims. We then received another denial stating that treatment as provided by an unlicensed individual, please be informed that the [sic] all our therapist and physical therapist assistance are licensed as you will see with the supporting documentation."

Amount in Dispute: $3,512.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please not that the dates of service 3/19/12 and 3/13/12 should be dismissed from this dispute for lack of timely filing. As this DWC-60 was received by Medical Fee Dispute Resolution on 3/14/12, neither the date of service 3/9/12 nor 3/13/12 were filed within the one year of the date of service pursuant to the requirements of DWC Rule 133.307 (c)(1)(A)."

Response Submitted by: Downs Stanford, P.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 13, 2012 to March 7, 2012	97530-GP, 97110-GP, 97016-GP and 97002-GP	$3,512.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.

2. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- B13 – Payment for service may have been previously paid
- 193 – Original payment decision maintained
- 168 – No additional allowance recommended
- B20 – Srvc partially/full furnished by another provider
- 197 – Payment adjusted for absence of precert/preauth
- 29 – Time limit for filing claim/bill has expired
- RM2 – Time limit for filing claim has expired
- QA – Adjustments due to bundling or unbundling
- 125 – Denial/reduction due to submission/billing error
- 198 – Payment adjusted for exceeded precert/preauth
- RM7 – Invalid code for CMS payment-resubmit w/valid code
- Note: Per Rule 133.20(e)(2) a medical bill must be submitted in the name of the licensed HCP that provided the health care or that provided direct supervision of an unlicensed individual who provided the health care. Per report, A.B., PTA rendered service
- 96A – Additional documentation provided

Issue

1. Did the requestor waive the right to medical fee dispute resolution?

Findings

28 Texas Administrative Code §133.307(c) (1) states: "Timeliness. A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. (A) A request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The dates of the services in dispute are January 13, 2012 through March 7, 2012. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on May 14, 2013. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307, subparagraph (B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

The Division finds that the requestor has waived the right to medical fee dispute resolution for the services in dispute. For that reason, the merits of the issues raised by both parties to this dispute have not been addressed.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	September 26, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.